NUCLEAR WAR

Sir,
Possibly the greatest environmental hazard threatening our patients is that of nuclear war. Implicit in the treatment this topic receives from the media is the notion that the effects of such a war on the populace and their environment can be contained by medical and public health measures. I do not think I am alone in believing that there is no effective medical response to a nuclear attack and that we have a duty to tell our patients so. If as a profession we remain silent, we foster the idea that realistic medical dispositions for such a disaster exist and we thus help to condition people to the view that nuclear conflict is acceptable, tolerable, survivable.

Is this not a topic which demands the attentions of this College, and one on which our views should be made public?

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Sir,
Public discussion of plans to increase the nuclear weapons based in this country and of civil defence preparations for nuclear war have been growing noticeably during the last 12 months.

It is argued by some that it is only the existence of balanced strategic nuclear weapons on both sides and the policy of deterrence by mutual assured destruction that has maintained peace in Europe for the last 35 years. Whatever the merits of that argument may be, it is no longer applicable. Official NATO policy now embraces the idea of 'theatre' nuclear war to be fought in Europe using 'tactical' nuclear weapons such as are carried by the Cruise missiles soon to be based in this country and the more recently resurrected neutron bomb. For the policy to appear credible to a potential enemy it is necessary that this country give the impression of being prepared to suffer and attempt to survive a nuclear attack. That is what the civil defence plans are all about.

In recent months many general practitioners have attended meetings organized by the Area Health Authorities to discuss the involvement of medical personnel in civil defence preparations. The general public is assured that the Casualty Collecting Centres will be established as soon as conditions permit after a nuclear attack and they will be run by local general practitioners and other available medical personnel. Whether we like it or not, we general practitioners are being assigned an active role in this nightmare. I cannot be alone in having been asked by patients for reassurance that the 'death pill' would be available in the event of a nuclear war.

We know probably better than anyone that the present high standard of medical care available to our patients depends upon an extremely complex organization of public health measures, sanitation, manufacture and distribution of vaccines, drugs and dressings, availability of transport and specialized hospital services dependent on highly developed technology. The NATO predictions of the degree of damage to be experienced in this country in the event of a nuclear war leave only 15 to 30 per cent of the population still alive, all services such as water, electricity and telephones unavailable and road communications impossible. The 30th Pugwash Conference (1980) recently came to the conclusion that "Effective civil defence against nuclear attack is impossible". It is unethical for us to join in this pretence that we can offer any form of medical care to the survivors of such an attack. The effects of nuclear war constitute an untreatable disease; the only logical approach is prevention.

Recently many doctors who have become aware of their responsibility to inform the profession and the public of the fallacies of the civil defence plans have come together from all parts of Britain to form The Medical Campaign Against Nuclear Weapons. The aims of the movement are to collect, review and disseminate information on the medical implications of nuclear weapons and to bring this to the attention of all concerned with public policy. Any colleagues who are interested may obtain further information from MCANW, 120 Edith Road, London W14.

As the Home Office presumes that general practitioners are prepared to play an active role in the charade of civil defence, perhaps it is time for the Royal College to consider the matter and to let the Minister know that, from a medical point of view, his plans are deceitful and unacceptable.

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Reference

30th Pugwash Conference, Netherlands (1980). Statement.

WHY NOT A STANDARD SUMMARY CARD?

Sir,
I was interested in Dr Sackin's "Why Not?" article (April *Journal*). His description of the use of summary cards seems to me somewhat complicated. We have modified the system using existing cards to give us problem-orientated records.

Our written records contain three sheets stapled together. The first sheet is a summary care FP9 which we label 'present'; in other words, these are present problems. The next sheet is again an FP9A or B summary card, which we label 'past', that is 'inactive' problems. This in effect is simply a case summary. The third card is an FP7A which is the immunization record card, and on the back of that card we put a drug summary. Because the three cards are stapled together, they form a unity which is very easy to spot.

The nice thing about this method is that it does not cost anything. It is very time consuming and has to be kept updated; nevertheless we find it of very great help.

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DECLINING STANDARDS IN GENERAL PRACTICE?

Sir,
There are two trends emerging in general practice which seem to me to be somewhat undesirable, not conducive to the best standards of general practice and which perhaps the College might like to consider.

The first is the tendency amongst general practitioners to request domiciliary visits by consultants without themselves attending. I am well aware, from personal experience, of the pressures that make such attendance difficult, but it seems to me that not to do so is regrettable for the following reasons: firstly, it is in my opinion somewhat discourteous on the part of a general practitioner to ask a consultant to visit a patient at home and not be present in order to introduce the consultant to the patient, and also to have available the patient's records in order to give him the full clinical picture. Secondly, I have always found that a domiciliary consultation helps to cement a relationship between the general practitioner and consultant and that it is commonly a very instructive and educational occasion.